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ABSTRACT

Therapy dropout is a statistically significant problem. The causes and effects of the high dropout rate still are not known. In this study the therapists' and clients' opinions of the desirability of staying in treatment were compared. At treatment termination clients (N=176) and their therapists (N=22) independently identified clients' termination status. Measures used included the Brief Symptom Inventory; the Child Behavior Checklist; the Therapist Problem Rating; the Client Problem Rating; and Client Satisfaction Rating. Client termination reasons fell into these categories: problem improved; dislike of therapist/therapy; and environmental restraints or considerations. Outcome and satisfaction data were also gathered. There was substantial disagreement between the two (client and therapist) sets of termination classifications. While traditional outcome measures were little related to termination status, satisfaction was highly related to both client and therapist classifications and their interaction. Satisfaction was best explained as a joint function of both client and therapist classification. Results help to explain inconsistencies between client and therapist ratings of outcome. Future research would do well to try to identify client factors that are associated with satisfaction, the most robust measure employed in this study. (ABL)

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Client vs. Therapist Perceptions of Psychotherapy Dropout and Outcome

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Abstract

At treatment termination, clients (n=221) and their therapists independently identified clients' termination status. Outcome (BSI, Client Problem Ratings, Therapists' Problem Ratings) and satisfaction data were also gathered. There was substantial disagreement between the two (client and therapist) sets of termination classifications. While traditional outcome measures were little related to termination status, satisfaction was highly related to both client and therapist classifications and their interaction. Satisfaction was best explained as a joint function of both client and therapist classification. Results help explain inconsistencies between client and therapist ratings of outcome.

Client vs. Therapist Perceptions of Psychotherapy Dropout and Outcome

Why do people seek treatment and then quit in the early stages of the very treatments they sought? Baekeland and Lundwall (1975) reviewed 362 studies of dropout literature and found, among general psychiatric clinics, 20% to 57% of patients failed to return after the first visit and 31% to 56% attended no more than four.

Clearly, therapy dropout is a statistically significant problem. Sue, McKinney & Allen, (1976) as cited by Bergin & Garfield, (1986) found that 23% of the cases actually starting therapy dropped out after the first session and 69.9% dropped out before the tenth session. Phillips & Fagan (1982) (as cited in Bergin and Garfield, 1986) found 49% failed to come to the first therapy session. Comparable figures are reported in private practice with 63% terminating before the tenth session (Baekeland & Lundwall, 1975). Wierzbicki and Pekarik's (1992) meta-analysis of over 100 studies identified an average dropout rate of about 50%.

The causes and clinical effects of this high dropout rate still are not know (Pekarik, 1992). Social class, income, and education have been most frequently cited as cause for these high rates (Baekeland and Lundwall 1975; Garfield, 1986). The relationship of these and other demographic and diagnostic variables to dropout is only moderate at best (Pekarik, 1985).

Pekarik (1986) looked at outcome of the "completer" and that of the "dropout". He found that appropriate terminators have a very high success rate while outcome for dropouts is variable. There is a distinction between early (1-3 visits) and late dropouts (4 or more visits). Clients who drop out after attending several sessions attain extremely variable outcome, with post-treatment symptoms levels distributed among high, medium and low symptoms. Early dropouts differ from late dropouts and completers. They are generally found unimproved or worse in symptomology and at follow-up.

The inconsistent outcome results may be due to the lack of a consistent reliable definition of the "dropout". In some areas dropping out is a black and white issue. In education, not completing or failure to obtain a degree undisputedly defines the client or student as a dropout. Much of the dropout research in psychotherapy may incorrectly imply such an universal understanding of the definition of dropout.

Garfield (1986, pg.219) defines the term "dropout" as "one who has been accepted for psychotherapy, who actually has attended at least one session of therapy and who discontinues treatment on his/her own initiative by failing to come for any future arranged visits with the therapist".

Traditionally there have been three methods of determining a dropout in psychotherapy: number of visits, failure to attend last appointment, and therapist reports.

The least valid definition is number of visits. Defining drop out rates by minimum duration of treatment is inherently flawed. Different treatment processes, (i.e. brief vs. traditional) require different numbers of visits by the very nature of the therapy practice. The client that successfully learns coping skills in three visits from brief therapy and moves on may be considered a dropout. Conversely, the client who is unsuccessful in a treatment program for months or years, who becomes frustrated at a lack of progress, and then quits would not be counted in this method of defining drop out rates. Contrary to many traditional expectations of psychotherapy, research clearly documents that most clients remain in therapy for only a few sessions, the median number of visits being four or five (Pekarik, 1986).

The second method commonly used to define dropout is to identify those clients who fail to attend their last scheduled visit. This definition does allow reliability within a study and has the advantage of ease of gathering data. Further there is little effect of therapist bias (unless the therapist scheduled the appointment). The primary weakness in this definition is to credit a patient status of completer for simply telling the therapist they are not coming back to therapy. The converse is true; a client who simply did not show for a "windup" session, even though relieved of their symptomology, is classified as a dropout (Pekarik, 1985b). Although the therapist believed the

client needed another appointment, the reason for not showing may well have been that the client felt he/she was finished and the appointment was unnecessary. Thus this method is superior to the duration criteria, but still has very significant shortcomings. Very few studies use this method.

The third method of determining premature terminators in psychotherapy has been to base the judgment on therapist report. The therapist, as an expert, is asked to judge whether the client "successfully completed" treatment. As with the other methods, this definition has problems. First, the client may view the treatment successful and effective while the therapist does not. The client may, and sometimes does, have completely separate and distinct expectations for treatment than does the therapist (Koppenhaver, 1990). A client may want help dealing with a spouse or coping with an errant child, yet may be seen by the therapist as having serious long term behaviors and attitudes that need to be adjusted or changed. While both are valid views and expectations, relying on therapist report alone presents only one side of the story.

The therapist has historically had primary input in the definition of premature terminators of treatment. When assessing dropout rates, both the method of treatment and its prescribed duration are controlled by the therapist. The appointment scheduling and the treatment goals are all intensely influenced and controlled by the therapist.

Treatment outcome success has long been based exclusively on the therapist's perceptions. A discrepancy between the therapist's view and the client's view of the outcome of treatment certainly exists. Outcome studies show a poor correlation (generally around .30) between therapist and client view of outcome (Garfield, 1986). Both views are considered necessary for an accurate view of outcome (Lambert, Shapiro, & Bergin, 1986).

Just as outcome researchers have overemphasized therapist assessment, dropout researchers rely almost exclusively on therapist's perceptions of termination status Generally dropout is defined by the therapist's view, be it recommended duration of treatment, the scheduling of last appointments, or subjective opinions as to readiness for termination. If there is little correlation between the client and therapist opinion on outcome, it stands to reason that clients and therapists would likewise be greatly different in defining dropouts and those who complete. Therapists may rate clients as dropouts while clients perceive themselves as completers.

An assessment of the relationship between client and therapist dropout definition is needed. The present study addressed this by obtaining both client and therapist categorizations of client termination status (completer and dropout). Outcome for clients in various termination groups was also assessed in order to test the validity of client versus

therapist perception of termination category.

Termination status is inherently a therapist notion; it assumes a dropout should have stayed in treatment. Client classification using this therapist concept simply tests the client's understanding of the therapist's desires for the client to stay in treatment. This study was interested in a comparison between the therapist's and client's opinion of the desirability of staying in treatment. Both client and therapist termination classifications were employed. In order to assess the validity of the two classification schemes, outcome and satisfaction data were gathered.

Method

Subjects

This study is part of a larger ongoing project that involved the assessment of treatment outcome of clients at three public mental health clinics. Two hundred forty-seven clients agreed to participate in the study. Of these, one hundred and seventy-six of these clients had the outcome and satisfaction measures required for this study and made up the subject pool that was categorized by client termination reason and therapist termination status.

The 176 clients who supplied follow-up information had the following characteristics: 47% were female, 91% were white, average education of client (or parent of client) was 14 years, 35% of the clients (or parents) were married, average income was

$15,000, average age of adults was 32 and average age of children was 10. Only 24 of the participants were children (age 17 or younger). This was partly due to the fact that one of the clinics only served adults. Disorders (DSM IIIR) were generally mild to moderate in severity. The most common were: Adjustment Disorders (48% of the cases), Dysthymic Disorders (13% of the cases), and Personality Disorders (8% of the cases). No other disorder or group of disorders accounted for more than six percent of the cases.

Consecutive non-emergency outpatient admissions assigned to participating therapists were asked to participate in the research project.

Therapists

There were 22 therapists with the following characteristics: 12 were male and 10 female; they averaged seven years of postgraduate experience; 19 had masters degrees, and 3 had Ph.D. degrees. There were 8 practitioners who utilized a family systems approach; 6 were cognitive behavioral in orientation; 4 were eclectic; 2 were Gestalt therapists; 1 was Adlerian; and 1 was a Reality therapist.

Procedures and Materials

At their intake appointment, clients were recruited by being given a Consent Form and then asked to complete a set of measures of adjustment. The same measures were re-administered two and five months after intake. At intake and termination of

treatment, therapist measures of client adjustment were obtained.

The Brief Symptom Inventory (B.S.I.; Derogatis & Spencer, 1982) was administered to all clients age 17 and older at intake, and two and five months after intake. The B.S.I. is a 53 item list of psychiatric symptoms. Clients were asked to rate the degree to which they have experienced each item in the preceding week. Ratings range from 0 ("not at all") to 4 ("extremely"). B.S.I. scores were obtained by summing the distress level reported for each item.

The Child Behavior Checklist (CBCL: Achenbach & Edelbrock, 1983) was administered to parents of clients age 2 to 16 at intake and between two and five months later. The CBCL is a 118 item list of behavior problems. Parents are asked to indicate if each problem description is "not true", "somewhat or sometimes true", or "very true or often true" for the client. Ratings range from 0 to 2. Scores were obtained by summing all parent ratings.

The Therapist Problem Rating was obtained at intake and again at termination. The therapist was asked (a) "Name the one or two problems which are most likely to be treatment targets for this client." The therapist was then asked to indicate on a 13 point continuum how much the problem bothers the client. Ratings ranged from 1 ("not at all") to 13 ("couldn't be worse").

A Client Problem Rating was obtained at intake and again at two and five month follow-ups. The client was asked to (a) "Name

the one or two problems for which you are most seeking assistance." On follow-up the client (or parent of client) was asked " How much does the problem which originally brought you (or your child) to treatment bother you now?". The clients were asked to use the same 13 point continuum used by the therapists to rate how much the problem bothered them.

A Client Satisfaction Rating was obtained at two and five month follow-ups. The client (or parent of the client) was asked four satisfaction questions: "Overall how satisfied were you with services received?" A five point Likert scale was provided for response; "very satisfied , somewhat satisfied, indifferent, somewhat dissatisfied and very dissatisfied."; "If you were to seek help again, would you return to this agency?; Would you recommend this agency to others needing help?" and "How would you rate your therapist?". A five point Likert scale was used for the yes and no questions; "definitely yes, probably yes, maybe, probably not and definitely not". The therapist ratings were, "excellent, very good, good, fair, and poor.".

Termination Classification

Client Termination Status. At two month and again at five month follow-up, clients who had terminated were asked "Did you terminate by mutual agreement with your therapist or did you 'drop out'?"

Client Termination Reason. Terminated clients were given the following list and asked to identify the item that influenced

their decision to terminate: "(a) therapy was complete, (b) The problem improved on its' own, (c) Therapy was not what I expected, (d) I felt I could get better help elsewhere, (e) I was not treated in a professional manner, (f) Fees were too high, (g) I had difficulty with transportation, (h) My work or daily schedule prevented me from attending, (i) Other activities prevented me from coming, (j) I didn't feel comfortable with the therapist that was assigned , (k) The stigma of coming to the clinic discouraged me, (l) I could not attend during the hours you were open, (m) Other _____". These reasons have been cited as the most frequently cited reasons for leaving treatment (Pekarik, 1983, 1991). These predominant reasons for leaving treatment were then divided into three major categories, a & b were considered "Problem Improved", c,d,e, & j were considered "dislike of therapist/therapy" and the remainder were considered "environmental restraints or considerations". "Other" responses were generally specific complaints, environmental or improvement statements that fit into one of the three major reasons for termination.

Therapist Termination Status. At termination, therapists classified client termination status using the following categories: (1) Evaluation only; (2) Treatment Completed; (3) Treatment not completed-agency decision; (4) Treatment not completed-client decision; (5) Transferred to another agency; (6) Client moved out of catchment area; (7) Client died; (8) Court

ordered treatment. In subsequent analyses, only categories "(2)" (Completer) and "(4)" (Dropout) were used.

At intake, consecutive admissions were given a consent form which explained the purpose of the research project, what participation would entail, and reassurances of confidentiality and voluntary participation. Upon agreeing to participate, clients (or the parents of clients) were given client problem identification and rating forms and BSI (or CBCL in the case of children) along with the standard intake form which requested demographic and insurance information. The therapists were given a problem identification and rating form at the initial visit.

During the study, visit activity of participating clients was monitored. At the time a client failed (without canceling) to attend a scheduled appointment for two consecutive weeks, a form was sent to his/her therapist requesting a termination classification and rating of problem improvement. If a client resumed treatment within a month, it was considered a continuation of the original treatment and therapist forms were sent at a later termination.

At two months and again at five months after intake, a follow-up telephone or mail contact was made with each client. During that contact, the client or parent was asked to provide the client problem and satisfaction ratings. In addition, a BSI or a CBCL was readministered at both times.

Results

Clients and therapists generally agreed on traditional therapist-oriented dropout and completer categorization: 83% (99 of 116) of clients identified by therapists as Dropouts identified themselves as Dropouts, and 78% (46 of 59) of client identified by therapists as Completers identified themselves as Completers.

Clients' Reasons for Termination were regarded as a client-oriented classification of termination status. Terminated clients (n=221) gave the following reasons for their termination: 44% (n=98) said their "Problem Improved", 32% (n=70) said they terminated due to "Dissatisfaction with their therapy or therapist", and 24% (n=53) said they terminated due to "Environmental Obstacles".

Since treatment completion implies satisfactory resolution of problems, agreement between client-oriented and therapist-oriented termination categories occurred when Completers said they terminated due to "Problem Improvement".
Similarly,agreement was achieved when therapist-categorized "Dropouts" claim they terminated due to "Dissatisfaction" or "Environmental Obstacles". Table 1 shows that only 52% (38 of 73) therapist classified Completers claimed to terminate due to "Problem Improved", and only 59% (88 of 148) of therapist classified Dropouts claimed to terminate due to "Dissatisfaction" or "Environmental Obstacles", i.e., 41% of Dropouts terminated

due to self-ascribed "Problem Improvement".

Insert Table 1 about here

A 2 (Therapist Classification) by 3 (Client Termination Reason) analysis of covariance (ANCOVA) using Therapist Termination Problem Ratings as the dependent variable with Therapist Intake Problem Ratings as the covariate found a significant Therapist Classification effect, $F(1,93) = 34.99$, $p < .001$ with lower (better) ratings for the Completers ($M = 5.13$ than Dropouts ($M = 8.32$). The Client Termination Reason was not significant $F(1,88) = 1.066$, $p < .368$.

This same 2 (Therapist Classification) by 3 (Client Termination Reason) ANCOVA was used with the BSI and Client Problem Rating as dependent variables. No significant Fs were found.

A 2 (Therapist Classification) by 3 (Client Termination Reason) analysis of variance (ANOVA) using a combined satisfaction rating as the dependent variable found a significant therapist Termination Classification effect, $F(1,92)=6.32$, $p < .001$, a significant Client Termination Reason effect $F(2,92)=14.84$, $p < .001$, and a two way interaction between Therapist Termination Classification and Client Termination Reason $F(2,92)=3.37$, $p < .05$. Table 2 shows the means and standard deviations for satisfaction among the Therapist Termination

Classification and Client Termination Reason groups. A one-way ANOVA using all six Termination Classification by Client Termination Reason group cells from Table 2 found that the Problem Improved Dropouts were significantly different (worse scores) than the Problem Improved Completers. In addition, the Dissatisfied Dropouts were significantly less satisfied than the Problem Improved Completers and both Environmental Obstacle groups.

Insert Table 2 about here

Discussion

The high level of agreement between therapists and clients when using the traditional Completer-Dropout Classification categories showed that the client has a clear understanding of their therapist's perception of termination. It seems clear that clients know whether the therapist wanted the termination to occur.

If therapists and clients perceived termination the same way there would be a predictable relationship between therapist termination status and client termination reasons: the therapist labeled Dropouts would have identified themselves as leaving treatment either because of dissatisfaction or environmental constraints and Completers would identify themselves as problem

improved.

The true picture is quite different. Not only is the agreement not complete but there is a wide diversity and a substantial lack of agreement of treatment termination status. Of the therapist-designated Completers, only about half (52%) of the clients cited Problem Improved as their termination reason, while 41% of the clients that therapists called Dropouts considered themselves to be Problem Improved. This clearly shows a different perception on the part of the therapists and clients and gives justification of taking into consideration client views in looking at termination status. Previous research that has addressed client reasons for termination has found a similar pattern to this research. This study found that 44% of clients terminated due to Problem Improved; 32% terminated due to Dissatisfaction of therapy or the therapist and 24% terminated due to Environmental Obstacles. Pekarik (1983) found much the same results with 39%, 26% and 35% respectively. Other studies have generally found the groups to be divided equally among the three termination reasons (Acosta, 1980; Garfield, 1963; & Pekarik, 1992).

The lack of agreement brings into question the validity of the two schema for termination classification. Since disagreement between client and therapist perceptions exists, both cannot be totally valid. The question becomes; Is one more valid than the other? To address this, outcome and satisfaction

measurements were studied both separately and in combination with both therapist and client classification.

Therapists' outcome ratings were found to be consistent with their own classification of termination status, that is, therapist-categorized Dropouts were consistently rated as less improved than therapist-categorized Completers. This would be expected given that the therapist concept of Completer is intrinsically tied to problem improvement, and that therapists are responsible for both of these measures. Other ratings (BSI, Client Ratings) were not significantly related to either client or therapist termination categorization.

Clients own termination reason is apparently not linked to their perceived problem improvement. No outcome measures were related to client termination reason. Other variables may be linked to client termination reason, such as the type of problem or the therapeutic approach used in dealing with the problem.

Clearly the strongest relationship between termination status and outcome held for satisfaction measures. Both client classification and therapist classification schema were related to satisfaction in expected ways. That is, overall, therapist-classified Completers were more satisfied than Dropouts and client-categorized Dissatisfied clients were less satisfied than Problem Improved and Environmental Obstacle clients. The Termination Classification by Client Termination Reason interaction revealed that the least satisfaction occurred for

Dissatisfied Dropouts, while the greatest satisfaction occurred for those clients who were both therapist-classified as Completers and client-classified as Problem Improved. The cells in Table 2 that were least influenced by the interaction of Client Reason and Therapist Termination status were the Environmental Obstacles groups: Environmental Obstacle Completers and Environmental Obstacle Dropouts were virtually identical. This seems to support the validity of clients' statements when they claim termination due to Environmental Obstacles.

The interaction also clearly showed that a clearer picture of clients at termination is presented when both clients' and therapists' perspectives are considered than when either is considered separately. For example, Dissatisfied Dropouts were clearly less satisfied than Environmental Obstacle Dropouts and Problem Improved Completers were much more satisfied than Problem Improved Dropouts.

While therapist Termination Classification was related to therapist ratings of improvement, the BSI and client ratings of improvement were not. Furthermore, Client Termination Reason was not at all related to BSI, Therapist Problem ratings and even Client Problem ratings. This shows that clients' perceptions of their termination reason seems more influenced by satisfaction rather than traditional outcome. Satisfaction seems to be determined by factors others than outcome. This is consistent

with other research which finds very small correlations between satisfaction and other outcome measures (Garfield, 1986).

In summary, this study shows that termination status, like outcome, is a complex phenomenon that is perceived differently by clients and therapists, and is differentially related to satisfaction and outcome measures. Future research would do well to further explore this distinction by trying to identify client factors that are associated with satisfaction, the most robust measure employed in this study.

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Table 1. Client vs. Therapist Perception of Termination

Therapist Rating of Treatment Termination	Client Perception of Termination: Mutual Agreement	Client Perception of Termination: Dropout	
Completer	46 (78%)	13 (22%)	n=59
Dropout	17 (17%)	99 (83%)	n=116

Table 2. Number of Clients in each Client X Therapist Category of Termination Classification

		Client reason for terminating treatment						
		Problem Improved		Dissatisfaction		Environmental Obstacles		
		n	%	n	%	n	%	
Therapist Rating of Treatment Termination	Completer	38	52%	21	29%	14	19%	(n=73)
	Dropout	60	41%	49	33%	39	26%	(n=148)
column totals		98	44%	70	32%	53	24%	

Table 3. Mean Satisfaction scores and standard deviations by Client Reason for Termination and Therapist Dropout Classification

			Client Reason for Terminating		
			Problem Improved	Dissatisfied	Environmental Obstacles
Therapist					
	Completer	n	15	7	16
		M	5.21	8.33	6.25
		SD	(1.76)	(3.93)	(2.08)
Classification					
	Dropout	n	5	19	32
		M	9.80	11.10	6.48
		SD	(1.79)	(4.29)	(2.54)

Note. Student -Newman-Keuls : group 4 > group 1; group 5 > group 1,3,6